STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	**5700 WILKIE DR FORT WAYNE, IN 46804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00200349, IN00200696 and IN00201600.

Complaint IN00200349-Substantiated, no deficiencies related to the allegations were cited.

Complaint IN00200696-Substantiated, no deficiencies related to the allegations were cited.

Complaint IN00201600-Unsubstantiated, due to lack of evidence.

Survey Dates: June 15, 16 & 17, 2016

Facility number: 000476
Provider number: 155446
AIM number: 100290870

Census bed type:
SNF/NF: 77
Total: 77

Census payor type:
Medicare: 10
Medicaid: 57
Other: 10
Total: 77

Sample: 4

Covington Manor Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00200349, IN00200696 and IN00201600.

QR was completed by 99993 on 06/20/16.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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